Department for Behavioral Health, Developmental and Intellectual Disabilities
Curriculum Application Form
Community Support Associate Initial 10 Hour Training Requirements

Today's Date:

Provider Information
Name of Provider:

Mailing Address Line 1:

Mailing Address Line 2:

City, State, Zip Code:

Contact Person
Name of Person Completing this Form:

Phone Number:

Email Address:

Author of Curriculum (if different from the Contact Person above)
Author Name:

Phone Number:

Email Address:

With this form, please include a USB flash drive with the curriculum saved as a pdf file. On the flash drive, clearly label the flash drive with the provider's name and author. Thank you.

Submit this information to:
Meg Link
Department for Behavioral Health, Developmental and Intellectual Disabilities
Outcome Transformation and Education Branch
275 East Main Street, 4E-C
Frankfort, KY 40621